

MEDICARE SUPPLEMENT INSURANCE PREMIUM COMPARISON GUIDE



State of Nevada
Department of Business & Industry
Division of Insurance
2013

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To be used with the Guide to Health Insurance for People with Medicare as developed by the National Association of Insurance Commissioners (NAIC) and the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services (CMS).

LETTER FROM THE COMMISSIONER

Dear Fellow Nevadan:

The decisions of whether or not to purchase Medicare supplement insurance, and which kind of insurance to buy, are important ones. However, shopping for this insurance requires time and effort and can be confusing. That is why we are pleased to provide you with Nevada's *Medicare Supplement Insurance Premium Comparison Guide*. This Guide provides valuable information that will assist you in comparing many of the Medicare supplement policies and Medicare Advantage plans currently being offered in Nevada.

You may wish to seek the advice of a licensed agent, broker, producer or consultant to assist you in selecting a Medicare supplement policy or Medicare Advantage plan. Another source of information is the Nevada Department of Health and Human Services, Division for Aging Services, which administers the Nevada State Health Insurance Assistance Program (SHIP). The program director and volunteer counselors are available to provide you with individual counseling concerning your questions on Medicare or Medicare supplement products.

Your insurance concerns are very important to us at the Division of Insurance. We are here to assist you with any insurance questions or problems you may have.

Our offices in Northern Nevada are located in Carson City. For information, please call our consumer services section at (775) 687-0700. In Southern Nevada, our offices are located in Las Vegas, and you may reach a consumer services officer at (702) 486-4009. The toll-free number for use in Nevada is 1-888-872-3234. The Nevada SHIP advisers may be reached at (702) 486-3478 in Las Vegas or toll free in Nevada at 1-800-307-4444.

Sincerely,



SCOTT J. KIPPER
Commissioner of Insurance

INTRODUCTION

Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill gaps in original Medicare plan coverage. Medicare does not pay for every medical expense which is why many people purchase supplemental insurance to fill the “gap” left by Medicare. Insurance companies may offer 10 standard policies and one high-deductible policy.

According to the Kaiser Family Foundation, 379,860 Nevadans were eligible to receive benefits through the federal Medicare program in 2012 (or 14% of the population). Of these, 120,379 individuals (31.7%) received their benefits through Medicare Advantage Plans. The remaining 259,481 Medicare recipients (68.3%) received their benefits through traditional fee-for-service Medicare.

The Nevada Division of Insurance (“Division”) surveyed the companies writing Medicare supplement coverage in Nevada to collect information on the premiums for the policies. Participation is voluntary and the results of that survey are summarized in the section titled *Premium Comparisons* (pages 28 - 31). The comparisons shown in the Guide will give you a start in shopping for Medicare supplement coverage by offering a means for comparing premium costs on policies.

Although Medicare supplement insurance is sold mainly to senior citizens, a few insurance companies offer coverage for disabled persons under the age of 65 who qualify for Medicare benefits. At publication time, no companies are willing to offer policies to Nevada residents under 65. However, this is subject to change.

This Comparison Guide is designed to help you decide on health insurance coverage to supplement your Medicare. It does not explain Medicare itself. If you already have Medicare, you may want to read “Medicare and You,” a guide published by the Centers for Medicare and Medicaid Services. “Medicare and You” summarizes Medicare benefits, rights and obligations, and provides answers

to the most frequently asked questions about Medicare. This information is also on Medicare's website: <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

If you are not yet on Medicare, or if you have misplaced your copy of the handbook, you may obtain another copy and other information from the Division, the Nevada State Health Insurance Assistance Program (SHIP) or your local Social Security office. Please see pages 53 - 55 of this Guide for contact information.

DEFINITIONS

The following terms are commonly used in Medicare supplement and long-term care insurance policies. Definitions differ from policy to policy, so it is important to understand the definition used in a specific insurance policy before you purchase it.

Allowed, approved, or eligible charges: The basis by which Medicare pays for health care costs. The approved charge paid by Medicare may be only 60 to 80% of the actual charge.

Assignment: In the original Medicare plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the original Medicare plan, it can save you money if your doctor accepts assignment. If your doctor doesn't accept assignment, you may still be able to see the doctor but you will need to pay the excess charges above what Medicare would pay.

Advance directives: Legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself.

Attained Age: Current age of an insured person, computed by adding the period elapsed since issue of insurance policy to his or her age when the policy was issued.

Benefit: A benefit is a health care service or supply that is paid for in part or in full by Medicare.

Benefit period: A specified number of days, months or years for which benefits will be payable during any one confinement or spell of illness, or for successive confinements for the same condition.

Body mass index (BMI): A measure of body fat based on height and weight that applies to both adult men and women.

Chronic: A chronic condition is one lasting three months or more.

Co-insurance or co-payment: The portion of a charge for a covered medical service that you must pay out of your own pocket. For example, Part B of Medicare generally has a required co-payment of 20% of the Medicare-approved amount for a covered service.

Custodial care: The level of care required to assist an individual in the activities of daily living. This care helps meet personal needs and can be provided by persons without professional licenses or extensive training.

Deductible: The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer.

Effective date: The date on which insurance coverage goes into effect. It is not always the same as the date the application is completed.

Enrollment period: A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Excess charges: The portion of the Medicare provider's charges which exceed Medicare's approved payment amount.

Exclusion or limitation: A specific service, expense, condition or situation not covered by an insurance plan.

Fee for service: In health care, a payment mechanism in which a provider is paid for each individual service rendered to a patient.

Guaranteed issue: A policy of insurance that will be issued regardless of health condition.

Guaranteed renewable: The policy must be renewed by the company except for non-payment of premiums and / or material misrepresentations.

Health maintenance organization (HMO): A type of Medicare Advantage plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists or hospitals on the plan's list, except in an emergency. Your costs may be lower than in the original Medicare plan.

Health Savings Account (HSA): Health Saving Accounts (HSAs) are tax-advantaged savings accounts that can be used to pay for medical and retiree health expenses incurred by individuals and their families. They are available to anyone who enrolls in a high-deductible health insurance plan.

However, current tax laws do not allow Medicare beneficiaries to either contribute to their existing account or enroll.

Home health care: A wide variety of skilled nursing care and supportive services for individuals who do not need institutional care. The services are available through intermittent visits and may include nursing care, physical therapy, speech and hearing therapy, occupational therapy, social services, and other support services.

Intermediate care: Less intensive care than skilled nursing care. Its definition may vary from policy to policy. It usually includes assistance with activities of daily living with the availability of any on-duty registered nurse.

Issue Age: These policies are priced at your age when you initially purchase the policy.

Lapse: Termination of a policy due to failure by the policyholder to pay the required premium within the time specified in the policy.

Limiting charge: The highest dollar amount you can be charged for a covered service by doctors and other health care providers who do not accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment. (See Approved Amount; Assignment.)

Long-term care: A wide range of routine and complex services designed to provide maintenance, preventive, rehabilitative and supportive services to

those individuals who have conditions that impair their ability to function independently.

Managed care: A system of health care where the goal is a system that delivers quality, cost-effective health care through monitoring, utilization review, and preventive services.

Medically necessary: Reasonable and necessary services for diagnosis or treatment as generally accepted by health care professionals that are clinically appropriate with regard to type, frequency, extent, location and duration; not primarily provided for the convenience of the patient, physician or other provider of healthcare; required to improve a specific health condition of an insured or to preserve his existing state of health; and the most clinically appropriate level of health care that may be safely provided to the insured.

Medicare Advantage plan: A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plans, and are not paid for under Original Medicare.

Medicare managed care plans: These are health care choices (such as HMOs) in some areas of the country. In most plans, you can only go to doctors, specialists or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, such as preventive care

not covered by Medicare. Your costs may be lower than in the original Medicare plan.

Network: A list of primary care doctors, specialists and hospitals that members of a managed care organization can go to. Doctors, hospitals and other health care providers who have contracted with the health insurer or a third-party administrator provide health care at a reduced rate to members within the network.

Open enrollment: A period when new beneficiaries may elect to enroll in a policy of insurance regardless of health. For a Medicare supplement policy this period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B.

Out-of-pocket costs: Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

Point of service (POS): A managed care plan that allows you to use doctors and hospitals outside the plan for an additional cost. (See Medicare managed care plan.)

Pre-existing condition: A medical condition for which medical advice was given or treatment was recommended or received from a doctor within a specified period before the effective date of coverage.

Preferred provider organization (PPO): Health service organization plan with a network of physicians and suppliers who contract to provide services to a health insurance plan on a discounted fee-for-service basis.

Skilled nursing care: Medically necessary care that can only be provided by, or under the supervision of, skilled, licensed, medical professionals such as registered nurses or professional therapists. All skilled services require a physician's order. Medicare's definition of "skilled nursing care" is often different from the definitions used in many Medicare supplement and long-term care insurance policies.

State Health Insurance Assistance Program ("SHIP"): SHIP refers to a group of federal and state funded programs. These programs work together to provide assistance with public and private health insurance issues as well as options for Medicare beneficiaries or those soon to be Medicare beneficiaries, their families and caregivers. SHIP has a centralized component of statewide assistance and a local component of county- and tribal-based benefit counselors.

TRICARE: TRICARE is the health care program serving Uniformed Service members, retirees and their families worldwide.

Underwriting: The process by which an insurer determines whether or not, and on what basis, it will accept an application for insurance.

Usual and customary or reasonable charges: The fee most commonly charged by physicians or providers for a particular service, treatment or supply. This fee may vary from area to area throughout the state.

NEW IN MEDICARE

Medicare now covers depression screenings, screenings and counseling for alcohol misuse and obesity, behavioral therapy for cardiovascular disease, and more.

If you reach the coverage gap (donut hole) in your Medicare prescription drug coverage (Part D), you'll pay only 47.5% for covered brand-name drugs and 79% for generic drugs.

10 MEDICARE SUPPLEMENT PLANS: A THROUGH N

You can choose from 10 different Medicare supplement policies. No matter what company you buy from, the 10 plans are identical from company to company. However, some plans provide extra benefits. An insurer may not offer all plans. The plans are described on the chart on page 27, which shows the benefits in each plan. These same charts will be included in every company's sales material. In addition to the 10 plans, insurers may offer one high-deductible version of Plan F. This plan includes the same coverage as Plan F, except the policyholder is responsible for the first \$2,110 of medical expenses each year (adjusted annually). The premium for this high-deductible plan is significantly less than the premium for regular plans.

Plans K and L cover 50% and 75%, respectively, of the co-insurance for basic benefits, skilled nursing and the Part A deductible. Once you reach the annual limit, K and L pay 100% of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does **not** include charges from your provider that exceed Medicare-approved amounts, called "excess charges." You are responsible for paying excess charges unless you have Medicare supplement policies F, G, or high-deductible Plan F, which cover 100% of the Medicare Part B excess charges.

Medicare Parts A, B, C, and D

- Medicare Part A typically pays for your inpatient hospital expenses,
- Medicare Part B typically covers your outpatient health care expenses including doctor fees. Remember, a benefit is a health care service or supply that is paid for in part or in full by Medicare.

TIP: You may have to use certain Medicare-contracted suppliers to get certain durable medical equipment in some geographic areas. Call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1 (877) 486-2048.

- Medicare Part C (Medicare Advantage plans) must cover at least the same benefits covered under Medicare Part A and Part B. However, your costs may be different, and you may have extra benefits, such as coverage for prescription drugs or extra days in the hospital. You should contact your Medicare Advantage plan administrator for specific coverage information for the plan in which you are enrolled. **Note: Not all doctors accept Medicare Advantage plans, so be sure to check first!**
- Medicare Part D provides drug coverage. There are two types of Medicare plans that may help lower prescription drug costs and help to protect against higher costs in the future. There is prescription drug coverage that is a part of Medicare Advantage plans (see Part C) and other Medicare health plans. Your Medicare Parts A and B health care would also be provided through these plans. There is also Medicare prescription drug coverage, called Medicare Part D, that provides additional coverage to the original Medicare plan, and some Medicare cost plans, and Medicare private fee-for-service plans. These Medicare Part D plans are offered by insurance companies and other private companies approved by Medicare. **Note: Different plans cover different prescriptions, so you will want to review each carefully. You choose the drug plan and pay a monthly premium. If you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later.**

MEDICARE SUPPLEMENT INSURANCE

SHOPPING TIPS

You May Not Need Medicare Supplement Insurance

If your income is low, you may qualify for a government program that will fill in the gaps in your Medicare coverage. Check with your local Welfare office (visit its website at <https://dwss.nv.gov/> or call the State's toll free number at 1-800-992-0900) to find out if you are eligible for **Medicaid** or if you are a **Qualified Medicare Beneficiary (QMB)**, **Specified Low-Income Medicare Beneficiary (SLMB)** or a **Qualified Individual (QI)**.

One Policy is Enough

You do not need more than one policy. If you already have a policy and want better benefits, you may be able to **replace** the policy with a new one. Once you receive the new policy you should drop the old one. **Caution:** Premiums paid in advance are sometimes non-refundable. Example: If you have paid for a one-year policy period and decide to cancel in the middle of the policy term, the premium may be earned by the company when paid by you and there may be no provision for a refund of premium at any time during that policy period.

Right to Coverage

The best time to buy a Medigap policy is during your Medigap open enrollment period. This period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B.

If you apply for a policy after that six-month period, some companies will reject your application if your health is not good. If you joined Medicare because of a

disability before you turned 65, federal law now requires that you be given an open enrollment opportunity when you turn 65.

Shop for Benefits, Service and Price

Check the chart of the 10 plans on page 27 to see the benefits that are included in each plan. Every company must use the same letters (A through N) to label its policies. Plan A will always be a company's lowest-priced Medicare supplement policy. It covers valuable basic benefits and must be sold by every company. Plans B through N add other benefits to fill different gaps in your Medicare coverage.

Use the Medicare Guide

The *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* ("Guide"), written by the federal government and the National Association of Insurance Commissioners (NAIC), has excellent information about Medicare, as well as health insurance. Any agent or company that offers to sell you Medicare supplement insurance must give you a copy. Upon request, a copy of the Guide is also available from the Division of Insurance, the Division for Aging Services or the State Health Insurance Assistance Program ("SHIP").

Read the Outline of Coverage

The outline of coverage for Medicare supplement insurance includes more details about each of the benefits in the policy. The outline of coverage only describes the policy in general terms. You need to read the actual policy for the details of your coverage. When reviewing the policy, spend extra time studying the provisions about pre-existing conditions.

Evaluate Your New or Existing Policy

Before buying any new insurance, read your existing policy. Don't change policies just to get a lower price. Premiums can change, and a new policy may not remain less expensive than the old one. Ask yourself, **“Would a new policy really improve my health coverage?”** Perhaps your old policy can be updated to provide the additional coverage you want.

- **Contact The Insurance Division @ 775-687-0700 to confirm that the company is licensed.**
- **Ask** how an insurance company prices Medigap policies. The manner in which they set the price affects how much you pay now and in the future.
- **Ask** if there are factors other than age that may affect the cost of your Medigap policy. Policies may have discounts based on your sex, whether you smoke, whether you are married and/or if you have automatic bank withdrawal.
- **Ask** the reference section of your local public library for financial rating publications that summarize an insurance company's financial position. Some publications rate companies by letter grades, which can be informative. Four organizations are commonly relied upon to rate insurance companies: A.M. Best, Standard & Poor's (S&P), Moody's Investor Service and Fitch Ratings. The role of these agencies is to assess the debt and financial strength of companies by providing a neutral analysis. In rating debt and financial strength, these agencies assist in judging an insurer's ability to meet their claims paying obligations. If an insurance company

cannot pay future claims or benefits, all other considerations, such as coverage and pricing, become relatively unimportant.

- **Before joining a plan**, be sure to carefully read the plan's membership materials and enrollment forms to learn your rights and the nature and extent of your coverage. Remember, PPO plans pay less for any non-emergency claims from providers outside your service area.
- **Discuss the policy** with a relative, friend, Division of Insurance, or someone else whom you trust before buying. When buying by mail, check whether the company has a local agent or a toll-free number that you can call for answers to your questions and for help in filing claims. Also, it is wise to consider factors other than price when selecting a policy, including claims handling and a company's reputation for service. Ask friends and family members about their experience with various companies.
- **Compare** before you buy. Shop around and talk to several agents and companies before making a decision. When shopping for a Medigap policy, be sure you are comparing the same policy. Do not be embarrassed to ask questions. Do not buy a policy until you are satisfied with the answers you receive. **Shop around with care.** Even the standardized plans may vary widely in cost.
- **Get** a copy of the policy.
- **Group coverage** is marketed through employers, labor unions and various private associations. If you have group insurance, ask before retirement if

you can continue your employee health insurance or convert it to suitable group Medicare supplement coverage after you turn 65. Group insurance often costs less and is more comprehensive than individually purchased coverage. Also, if your spouse is included in your group health plan, be sure to check on his or her eligibility.

- **If you change policies**, remember that your pre-existing conditions are covered immediately when you have been covered for a total of six months under both policies.
- **Make sure** you really need Medicare supplement insurance before you buy. People who are eligible for Medicaid don't need Medicare supplement insurance. To find out if you are eligible for Medicaid, contact the State Department of Health and Human Services, Division of Welfare and Supportive Services (DWSS) in Reno at (775) 684-7200, (702) 486-1646 in Las Vegas/Henderson, or toll free: (800) 992-0900. For a complete list of local phone numbers you may visit <https://dwss.nv.gov/>.
- **Take full advantage** of your “free look” period by carefully reviewing your new policy. You have 30 days from the date you receive the policy to return and cancel it for a full refund. Read the policy when it arrives; don't wait until the last minute. If you find it difficult to understand, get help from a friend, relative or someone else you trust. Similarly, the Division of Insurance Consumer Services section (775-687-0702 and 0703) can help you understand what your policy covers. Also, some senior citizen organizations have volunteer insurance advisors. See pages 53 - 55 for information

regarding senior resources and Nevada's State Health Insurance Program (SHIP).

Avoiding Fraud

- **Buying locally** from a licensed agent with a good reputation is safer than buying from someone you do not know. A traveling agent may never return to your area.
- **Be careful** to answer all questions accurately. Don't let the agent fill out the application for you. If an agent helps you to complete the application, do not sign it until you are sure that all questions have been completely answered and all requested medical information is included and correct. The omission of information may cause the company to deny your claims or cancel your policy.
- **Do not** pay cash or make a check out to the agent or in the agent's name. Checks should be made payable **only** to the insurance company. Get a receipt for all payments
- **Don't be misled** into believing that a Medicare supplement policy is endorsed by or sold by the state or federal government. Although the Division of Insurance reviews Medicare supplement policy forms to make sure they meet Nevada requirements, the Division does not endorse particular companies or policies. It is a violation of federal and state law for insurance companies or agents to suggest they are acting on behalf of the government when selling Medicare supplement insurance.

- **Don't be pressured** to buy insurance on the agent's first visit. If you can, invite a trusted friend or relative to be present during the agent's visit. An agent who objects to this may not be the right agent for you.
- **Don't be stampeded** by statements that a certain policy or premium rate will be available only for a limited time. Such statements are seldom true.

Completing the Application

- **Be careful** to answer all questions accurately. Don't let the agent fill out the application for you. If an agent helps you to complete the application, do not sign it until you are sure that all questions have been completely answered and all requested medical information is included and correct. The omission of information may cause the company to deny your claims or cancel your policy.
- **Be sure** you have the agent's name and address and the address of the company from which you are purchasing the policy. Know how to contact your agent or the company if you need help. **Always check the license status of the agent and the insurance company with the Division of Insurance.** You may also verify an insurance company on the Division's Web site at www.doi.nv.gov (see the License Look Up Tool link on the left) or through www.nvinsurancealert.com, an anti-fraud Web site coordinated by the Division along with the Nevada Surplus Lines Association and the Nevada Independent Insurance Agents. Or call 1-888-467-4195.
- **Never sign** a blank application form.
- **Read** what you are being asked to sign. If the agent tries to rush you, be suspicious.

- **Remember**, if you are replacing policies, you should have full coverage for all pre-existing conditions when you have been covered for six months under the old policy, the new policy or both. This should be explained to you in a Replacement Notice provided by the new insurance company or its agent. If you return the policy to the company, be sure to send it by certified mail with a return receipt requested. This will give you a record of the date it was returned in case there is a dispute.

Special Information for Military Retirees

You or your spouse may be eligible for TRICARE For Life if either has retired from the United States military service. The benefits covered by TRICARE For Life supplement Medicare coverage and eliminate the need for a Medicare supplement policy. In addition, TRICARE For Life benefits include coverage for outpatient prescription drugs not covered by Medicare. Unlike Medicare supplement policies, there is no enrollment fee to belong to TRICARE For Life. If you believe that you are eligible for this program you can contact TRICARE For Life at (866) 773-0404.

More Information is Available

The Division of Insurance Consumer Services section is happy to answer any additional questions you might have. If you have more questions about Medicare supplement insurance, contact us at:

**State of Nevada
Department of Business & Industry
Division of Insurance**

**Carson City Office (775) 687-0700; csc@doi.nv.gov
Las Vegas Office (702) 486-4009; edelacy@doi.nv.gov**

Refer to pages 53 - 56 of this guide for free counseling and other resources.

COST COMPARISON AND GUIDE TO PREMIUM CHART

This section of the booklet has a graph outlining the 10 standard plans and offers a comparison of premiums by plan and company. Companies are listed in alphabetical order.

NOTICE

The policy comparison section summarizes material submitted by the insurers. The figures are theirs, not those of the Division of Insurance. Some information may not be current at the time you read this publication. The policy itself becomes the contract between the insurance company and you, and will be the basis of final determinations. Only policies that meet the requirements of Nevada laws and regulations at time of publication are included.

Publication of this comparison is for informational purposes only. Inclusion of information about a policy in this brochure does not in any way constitute endorsement of a policy or company by the Division of Insurance.

GUIDE TO THE PREMIUM COMPARISON CHART

Annual Premiums

The premiums shown are only a sampling of the 2012 annual rates. Additional information regarding the rates can be obtained from the insurance company. The rates may change every year as companies file new rates with the Division of Insurance. Some companies expect you to pay every month, others bill every two to three months, and some bill annually. While rates can change because of an insurance company's increased claims for all similar policyholders, your premiums cannot increase based on your individual claims.

Age Groups

Premiums are based on your age when you buy the policy. Although companies may have a different premium for each age, this comparison shows premiums at five-year intervals (ages 65 and 70). It's important to remember that premiums will probably increase every year to keep up with Medicare changes. Companies also may increase premiums if overall claim expenses are higher than anticipated.

Premium Type

Companies have two different methods of pricing policies based on your age. These are shown in the "Prem Type" column.

- **Issue Age (I):** These policies are priced at your age when you initially purchase the policy. Your future rates will **not** increase because of age as you become older. If you buy the policy at age 65 you will always pay the premium that the company charges 65-year-old customers. However, your premiums can increase because of an insurance company's overall claims experience. While the initial rate for an **Issue Age (I)** policy may be greater than a similar **Attained Age (A)** policy, it could be less expensive over the life of the policy.
- **Attained Age (A):** In addition to the annual rate increases for changes in Medicare and overall claims experience, the premium will increase as you become older. If you buy a policy at 65, when you are 70 you will pay whatever the company is then charging individuals who are 70 years old.
- **No Age Rating (N):** The premium is the same for all customers who buy this policy, regardless of age.

Area

Some companies charge different premiums based on where you live.

Smoker

Some companies may charge different premiums for non-smokers and smokers. If this column has a **Y**, the company has two or more sets of prices. You should check with the company to find out if your premium would be higher or lower.

Sex

Premiums are shown for women. A company with an **N** in this column uses the same rates for both male and female. A company with a **Y** in this column has different (usually higher) premiums for men.

Health Screening / Underwriting

Although most companies underwrite, some offer policies regardless of any health problems you may now have.

2013 POLICY BENEFIT CHART

Medicare supplement insurance can be sold in only ten standard plans and one high-deductible plan. This chart shows the benefits for each plan. Every company must make available Plan A. Some plans may not be available in Nevada.

Basic Benefits:

Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses - Part B coinsurance (generally 20 percent of Medicare-approved expenses) or co-payments for hospital outpatient services.

Plans K, L and N require insured to pay a portion of Part B co-insurance or co-payments.

Blood - First three pints of blood each year.

Hospice - Part A co-insurance.

A	B	C	D	F	F High Deductible*	G	K	L	M	N
Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance, except up to \$20 co-payment for office visit, and up to \$50 co-payment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	Part B Deductible					
				Part B Excess 100%	Part B Excess 100%	Part B Excess 100%				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4,800; paid at 100% after limit reached	Out-of-pocket limit \$2,400; paid at 100% after limit reached		

* Plan F also has an option called a high-deductible Plan F. This high-deductible plan pays the same benefits as Plan F after a calendar-year deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses equal to the annual deductible have been satisfied. Out-of-pocket expenses for this deductible are expenses that would ordinarily have been paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

2012 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 65

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	A	B	C	D	Benefit Plans A - N						HDF *
Aetna Life Insurance Company	1-800-345-6022	A	N	Y	6	1,412	1,563			1,767	1,640				1,284	
American Family Life Insurance Co (AFLAC)	1-866-708-6223	A	Y	Y	0	1,570		1,894	1,706	1,935	1,734				1,330	
American Republic Corp Insurance Company	1-888-755-3065	A	Y	Y	0	1,251				1,671		863	1,189			653
American Republic Insurance	1-888-755-3065	A	Y	Y	0	1,188		1,539								
Colonial Penn Life Insurance Company	1-800-800-2254	A	Y	Y	0	1,421	1,680			1,904	1,594	697	1,171	1,502	1,060	416
Combined Insurance Company of America	1-800-544-5531	A	N	Y	0	1,351				1,930					1,351	
Equitable Life & Casualty Insurance Company	1-877-358-4060	A	Y	Y	0	1,646				2,330					1,640	
Family Life Insurance Company	1-800-877-7703	A	Y	Y	0	1,244	1,512	1,736	1,588	1,808	1,595			1,429	1,266	
Forethought Life Insurance Company	1-877-492-5870	A	Y	Y	0	1,541		2,033		2,083	1,627				1,437	
Gerber Life Insurance Company	1-877-778-0839	A	Y	Y	0	1,284				1,809	1,396					
Globe Life and Accident Insurance Company	1-800-801-6831	A	N	N	2	1,001	1,476	1,650		1,667						
Heartland National Life Insurance Company	1-866-916-7971	A	Y	Y	0	1,325			1,606	1,930	1,632			1,502	1,294	
Humana Insurance Company	1-888-310-8482	A	Y	Y	3	1,658	1,804	2,119		2,162		972	1,382		1,333	744
Humana Insurance (Readers Digest)	1-888-310-8482	A	Y	Y	3	1,859				2,326		1,174			1,621	940
Liberty National Life Insurance Company	1-800-331-2512	A	Y	Y	2	1,472	2,045			2,317					1,766	427
Medico Insurance Company	1-800-228-6080	A	Y	Y	0	1,280			1,712	1,878						
Mutual of Omaha Insurance Company	1-800-228-9999	A	Y	Y	0	1,043				1,656	1,292					

* High Deductible Plan F

2012 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 65

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - N										HDF *
						A	B	C	D	F	G	K	L	M	N	
Physicians Mutual Insurance Company	1-800-228-9100	A	Y	N	0	909				1,115	1,237				965	486
Physicians Mutual Insurance Company	1-800-228-9100	I	Y	N	0	997				1,325	1,452				1,252	636
Rocky Moutain Insurance (Anthem)	1-877-831-3000	A	Y	Y	6	1,797				2,487	2,355				1,716	617
Royal Neighbors of America	1-800-568-2382	A	Y	Y	0	1,546				2,272	1,820					
SecureHorizons by UnitedHealthcare	1-800-768-1479	A	Y	N	0	1188				1598	1441	757	1041		1071	515
Sentinel Security Life Insurance Company	1-800-247-1423	A	Y	Y	0	1,231	1,354	1,672	1,441	1,712						
Standard Life and Accident Insurance Company	1-888-350-1488	A	Y	Y	0	2,155	2,454	2,790	1,681	2,294	1,694				1,106	334
State Farm Mutual Automobile Insurance Co.	See Local Agent	A	Y	N	0	1,134		1,710		1,727						
Sterling Investors Life Insurance Company	1-877-896-6434	A	Y	Y	0	1,335	1,559	1,866	1,633	1,938	1,642			1,469	1,357	763
Sterling Life Insurance Company	1-800-688-0010	A	Y	Y	0	1,675	1,917	1,948		1,857		797			1,356	
Thrivent Financial for Lutherans	1-800-847-4836	A	Y	N	0	1,055	1,247	1,615	1,388	1,621	1,428		997	1,262		530
United American Insurance Company	1-800-331-2512	A	Y	Y	2	1,328	1,917	2,182	2,012	2,196	2,023	1,248	1,756		1,664	403
United Commercial Travelers (The Order of)	1-800-848-0123	A	Y	Y	0	1,172	1,366	1,635	1,432	1,695	1,440				1,186	
UnitedHealthcare Insurance Company	1-800-523-5800	A	Y	3	0	1,129	1,501	1,723		1,737		686	957		1,203	
USAA Life Insurance Company	1-800-531-8722	A	N	Y	0	1,742				1,924						

* **High Deductible Plan F**

2012 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 70

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - N										HDF *
						A	B	C	D	F	G	K	L	M	N	
Aetna Life Insurance Company	1-800-345-6022	A	N	Y	6	1,701	1,912			2,168	2,032				1,598	
American Family Life Insurance Co (AFLAC)	1-866-708-6223	A	Y	Y	0	1,859		2,283	2,058	2,338	2,099				1,612	
American Republic Corp Insurance Company	1-888-755-3065	A	Y	Y	0	1,402				1,871		967	1,331			731
American Republic Insurance	1-888-755-3065	A	Y	Y	0	1,331		1,724								
Colonial Penn Life Insurance Company	1-800-800-2254	A	Y	Y	0	1,736	2,045			2,307	1,962	849	1,403	1,857	1,370	503
Combined Insurance Company of America	1-800-544-5531	A	N	Y	0	1,766				2,523					1,766	
Equitable Life & Casualty Insurance Company	1-877-358-4060	A	Y	Y	0	1,765				2,512					1,771	
Family Life Insurance Company	1-800-877-7703	A	Y	Y	0	1,479	1,801	2,069	1,889	2,125	1,899			1,701	1,487	
Forethought Life Insurance Company	1-877-492-5870	A	Y	Y	0	1,687		2,236		2,291	1,790				1,582	
Gerber Life Insurance Company	1-877-778-0839	A	Y	Y	0	1,519				2,144	1,655					
Globe Life and Accident Insurance Company	1-800-801-6831	A	N	N	2	1,334	1,824	1,996		2,015						
Heartland National Life Insurance Company	1-866-916-7971	A	Y	Y	0	1,619			1,995	2,336	2,030			1,866	1,598	
Humana Insurance Company	1-888-310-8482	A	Y	Y	3	1,960	2,133	2,505		2,556		1,149	1,633		1,576	879
Humana Insurance (Readers Digest)	1-888-310-8482	A	Y	Y	3	2,173				2,725		1,363			1,892	1,086
Liberty National Life Insurance Company	1-800-331-2512	A	Y	Y	2	2,024	2,842			3,211					2,513	621
Medico Insurance Company	1-800-228-6080	A	Y	Y	0	1,444			1,965	2,124						
Mutual of Omaha Insurance Company	1-800-228-9999	A	Y	Y	0	1,130			1,794	1,399						

* **High Deductible Plan F**

2012 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT AGE 70

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	A	B	C	D	Benefit Plans A - N						HDF *
Physicians Mutual Insurance Company	1-800-228-9100	A	Y	N	0	1,055				1,315	1,458				1,242	637
Physicians Mutual Insurance Company	1-800-228-9100	I	Y	N	0	1,099				1,574	1,698				1,516	801
Rocky Moutain Insurance (Anthem)	1-877-831-3000	A	Y	Y	6	2,165				2,970	2,837				2,049	737
Royal Neighbors of America	1-800-568-2382	A	Y	Y	0	1,768				2,596	2,082					
SecureHorizons by UnitedHealthcare	1-800-768-1479	A	Y	N	0	1389				1925	1759	893	1256		1348	655
Sentinel Security Life Insurance Company	1-800-247-1423	A	Y	Y	0	1,407	1,549	1,918	1,654	1,964						
Standard Life and Accident Insurance Company	1-888-350-1488	A	Y	Y	0	2,209	2,515	2,860	1,723	2,352	1,736				1,134	342
State Farm Mutual Automobile Insurance Co.	See Local Agent	A	Y	N	0	1,417		2,138		2,159						
Sterling Investors Life Insurance Company	1-877-896-6434	A	Y	Y	0	1,587	1,852	2,219	1,943	2,279	1,953			1,749	1,595	897
Sterling Life Insurance Company	1-800-688-0010	A	Y	Y	0	1,918	2,235	2,249		2,145		928			1,575	
Thrivent Financial for Lutherans	1-800-847-4836	A	Y	N	0	1,206	1,427	1,848	1,589	1,854	1,634		1,140	1,443		606
United American Insurance Company	1-800-331-2512	A	Y	Y	2	1,826	2,662	2,991	2,853	3,034	2,865	1,662	2,343		2,367	587
United Commercial Travelers (The Order of)	1-800-848-0123	A	Y	Y	0	1300	1517	1818	1591	1865	1599				1,306	
UnitedHealthcare Insurance Company	1-800-523-5800	A	Y	N	3	1,392	1,850	2,124		2,141		847	1,181		1,483	
USAA Life Insurance Company	1-800-531-8722	A	N	Y	0	2,038				2,250						

* **High Deductible Plan F**

MEDICARE OPTIONS

Original fee-for-service Medicare and original Medicare with a Medicare supplement policy are available to all Nevada beneficiaries who are age 65 or older, who are under age 65 with certain disabilities and to people of all ages with End-Stage Renal Disease (Note that very few insurers offer Medicare supplement policies to beneficiaries under age 65). However, there are also Medicare Advantage Plans (Part C) offered by private companies that provide Parts A and B (and sometimes Part D drug coverage) services to Medicare beneficiaries through special arrangements including HMOs, PPOs, and Managed Care Companies.

Medicare Advantage

The companies that offer Medicare Part C (Some plans include Part D Drug Coverage as well as Parts A and B) are as follows:

- **Aetna Medicare** (1-800-832-2640) – Clark County
- **Anthem Blue Cross and Blue Shield** (1-800-797-6403) – Washoe County
- **CareMore Health Plan of Nevada** (1-866-622-2820) – Clark County
- **Health Plan of Nevada** (1-877-271-8591) – Clark, Esmeralda, Lyon, Mineral, Nye and Washoe Counties
- **Humana** (1-800-833-2364) – Clark, Nye, and Washoe Counties
- **SecureHorizons by UnitedHealthcare** (1-800-555-5757) – Clark County
- **Senior Care Plus** (1-888-775-7003) – Carson City, Churchill, Douglas, Lyon, Storey, and Washoe Counties
- **Universal American** (1-800-996-8867) – Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, Storey and White Pine Counties

- **Universal Health Care** (1-800-965-7034) – Churchill, Clark, Eureka, Humboldt, Lander, Lincoln, Pershing, and Storey Counties

Original Medicare is the traditional fee-for-service Medicare and is available to all Medicare beneficiaries. Medicare Part A (hospital insurance) is available to all eligible Medicare beneficiaries without a monthly premium. You have the option to pay a premium for Medicare Part B (medical insurance) to receive those benefits. The Medicare Part B premium in 2013 is \$104.90 per month for most beneficiaries. Higher-income consumers may pay more. Under traditional Medicare, you can choose any health care provider who accepts Medicare. Medicare pays the provider each time you incur an expense. While Medicare pays its portion, you are responsible for paying the balance including deductibles, co-payments, co-insurance and the cost of services not covered by Medicare.

All newly enrolled Medicare beneficiaries are covered for an initial physical examination and for cardiovascular screening blood tests. People considered “at risk” are covered for a diabetes screening test for early detection and treatment of this life-threatening condition.

Original Medicare with a Supplement Policy

You can purchase a private Medicare supplement insurance plan (also referred to as “Medigap insurance”) to cover some of your obligations after traditional Medicare has paid its portion. You may purchase one of 10 standard Medicare supplemental insurance policies (Medigap or Medicare SELECT described below). The benefits provided by these plans are summarized on the policy benefit chart found on page 27. Most policies pay Medicare co-insurance amounts while others

pay Medicare deductibles. Some beneficiaries may already have supplemental coverage from other sources such as a former employer or Medicaid.

- **Medigap:** You can go to any doctor or hospital.
- **Medicare SELECT:** These plans are almost identical to standard Medigap insurance. When you purchase one of Medicare's SELECT policies, you're buying a standard Medigap plan. The only difference is that this type of plan operates like managed care plans. In other words, you **must** use plan hospitals and, in some cases, plan doctors in order to be eligible for full Medigap benefits.

Managed Care

Under a managed care plan, a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) offer comprehensive, coordinated medical services on a pre-paid basis. You pay your Part B monthly premium and Medicare makes a monthly payment to the plan. Some plans charge you an extra monthly premium. You may also be required to pay a co-payment per visit or service. The monthly premiums and co-payments will vary depending on the plan you choose and the county in which you live. A supplemental insurance policy is not necessary if you join a managed care plan.

- **HMO:** In a Health Maintenance Organization, you **must** use the plan's providers (doctors, hospitals, skilled nursing facilities and ancillary providers). These providers are paid directly by the HMO and you are only required to make small co-payments. These plans sometimes offer services that are not covered by traditional fee-for-service Medicare.
- **HMO with POS option:** Less restrictive than HMOs. When combined with a basic HMO package, the POS (point-of-service) option allows you to use doctors and hospitals outside of the plan for an additional cost.

- **PSO:** In a Provider Sponsored Organization you **must** use the plan's providers. These plans operate like an HMO; however, the plan is sponsored by the providers (doctors and/or hospitals).
- **PPO:** The in-network benefits are provided by the plan's providers (preferred providers). However, you can use doctors and hospitals outside of the plan for an additional cost.

Private Fee-for-Service Plan

In a private fee-for-service plan, you select a private insurance plan which accepts Medicare beneficiaries. You pay the Part B premium, any other monthly premium the private fee-for-service plan charges, and an amount per visit or service. While the plan, not Medicare, determines how much to allow for the service, the provider is allowed to charge more than the allowed amount and bill you for the difference. The plan may provide extra benefits that traditional Medicare does not cover.

Health Savings Account (HSA)

Health Saving Accounts (HSAs) are tax-advantaged savings accounts that can be used to pay for medical and retiree health expenses incurred by individuals and their families; and are open to anyone who enrolls in a high-deductible health insurance plan. However, current tax laws do not allow Medicare beneficiaries to enroll. HSAs fall under the jurisdiction of the United States Department of Treasury. If an individual ceases to be eligible or makes an ineligible withdrawal, penalties and taxes may apply. For assistance with HSAs, please contact your HSA trustee or visit the United States Department of the Treasury's Web site at www.treas.gov and click on Health Savings Accounts.

Medicare HMOs

An HMO that has a contract with Medicare must provide or arrange for the full range of Part A and B services if you are covered under both parts of Medicare.

HMOs can also provide benefits beyond what Medicare allows, such as preventive care, prescription drugs (limited amount), dental care, hearing aids, and eyeglasses.

Before joining a plan, be sure to read the plan's membership materials and enrollment forms carefully to learn your rights and the nature and extent of your coverage. If you belong to an HMO plan, the plan will not pay claims for any non-emergency benefits you receive from providers outside of the HMO. Below is a list of Medicare HMO companies in Nevada.

Clark County:

Aetna Medicare (800) 832-2640
CareMore Health Plan (800) 622-2820
Health Plan of Nevada, Inc. (800) 271-8591
Humana Health Plan, Inc. (800) 833-2364
SecureHorizons by UnitedHealthcare (800) 555-5757
Universal Health Care of Nevada, Inc. (800) 965-7034

Esmeralda County:

Health Plan of Nevada, Inc. (800) 274-6648

Lyon County:

Health Plan of Nevada, Inc. (800) 274-6648

Mineral County:

Health Plan of Nevada, Inc. (800) 274-6648

Nye County:

Health Plan of Nevada, Inc. (800) 271-8591
Humana Health Plan, Inc. (800) 833-2364

Washoe County:

Health Plan of Nevada, Inc. (800) 271-8591
Senior Care Plus (888) 775-7003

		Traditional Medicare	SENIOR CARE PLUS Value Basic Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Value Rx Plan (HMO) (Hometown Health Plan) Washoe County
		YOU PAY:	YOU PAY:	YOU PAY:
Premium		\$104.90 Part B	\$0 plus \$79.90 Part B Premium = \$66.40 (includes \$25 Part B Premium Rebate)	\$0 plus \$104.90 Part B Premium = \$104.90
Hospital Care	1 to 60 days	\$1,184	\$200 per day for 1-5 days (unlimited days)**	\$225 per day for 1-5 days (unlimited days)**
	61 to 90	\$296 a day	\$0	\$0
	91 to 150	\$592 a day	\$0	\$0
	Beyond 150	All costs	\$0	\$0
Doctors Visits Primary Care/Specialist	Per Visit	20% plus*	Preventive \$0 / PCP \$10 / Specialist \$40	Preventive \$0 / PCP \$10 / Specialist \$40
	Deductible	\$147	\$0	\$0
Prescription Copayment Preferred Generic Non-Preferred Generic Preferred Brand Non-Preferred Brand Specialty/Select Diabetic	Pharmacy - 30 days	Full Amount	No Coverage	Tier 1 - Pref Generic \$4, Tier 2 - Non-Pref Generic \$10 Tier 3 - Pref Brand \$45, Tier 4 - Non-Pref Brand \$80 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$10
	Mail Order - 90 days			Tier 1 - Pref Generic \$8, Tier 2 - Non-Pref Generic \$20 Tier 3 - Pref Brand \$90, Tier 4 - Non-Pref Brand \$160 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$20
Annual Limit		ICL - \$2,970		All generic drugs covered in the gap (tier 1-2)
Out-of-Plan Svs.	Urgent Care	NA	\$25 in-net / \$50 out-net (anywhere in United States)	\$25 in-net / \$50 out-net (anywhere in United States)
	Emergency Care	NA	\$60 (worldwide) - waived if admitted	\$60 (worldwide) - waived if admitted
Other	Vision	NA	\$20 Exam / 100% Lenses / \$100 Frames	\$20 Exam / 100% Lenses / \$100 Frames
Other	Dental	NA	No Coverage	No Coverage
Other	Fitness Benefit	NA	Fitness Club Membership Included	Fitness Club Membership Included
Phone Number:			(775) 982-3158	

* You pay 20 percent of the Medicare approved fee plus additional charges if the provider does not accept the Medicare approved fee in full.

** Service Period - There are no additional copayments for Inpatient Hospital-Acute Services when readmitted to a contracted facility during a service period or within 60 days of last discharge.

		Traditional Medicare	SENIOR CARE PLUS Value Rx Enhanced Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Value Rx Select Plan (HMO) (Hometown Health Plan) Washoe County
Premium		YOU PAY: \$104.90 Part B	YOU PAY: \$26.50 plus \$104.90 Part B Premium= \$131.40	YOU PAY: \$110 plus \$104.90 Part B Premium= \$214.90
Hospital Care	1 to 60 days	\$1,184	\$225 per day for 1-4 days (unlimited days)**	\$175 per day for 1-3 days (unlimited days)**
	61 to 90	\$296 a day	\$0	\$0
	91 to 150	\$592 a day	\$0	\$0
	Beyond 150	All costs	\$0	\$0
Doctors Visits Primary Care/Specialist	Per Visit	20% plus*	Preventive \$0 / PCP \$10 / Specialist \$40	Preventive \$0 / PCP \$10 / Specialist \$35
	Deductible	\$147	\$0	\$0
Prescription Copayment Preferred Generic Non-Preferred Generic Preferred Brand Non-Preferred Brand Specialty/Select Diabetic	Pharmacy - 30 days	Full Amount	Tier 1 - Pref Generic \$3, Tier 2 - Non-Pref Generic \$8 Tier 3 - Pref Brand \$45, Tier 4 - Non-Pref Brand \$80 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$10	Tier 1 - Pref Generic \$2, Tier 2 - Non-Pref Generic \$6 Tier 3 - Pref Brand \$45, Tier 4 - Non-Pref Brand \$80 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$10
	Mail Order - 90 days		Tier 1 - Pref Generic \$6, Tier 2 - Non-Pref Generic \$16 Tier 3 - Pref Brand \$90, Tier 4 - Non-Pref Brand \$160 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$20	Tier 1 - Pref Generic \$4, Tier 2 - Non-Pref Generic \$12 Tier 3 - Pref Brand \$90, Tier 4 - Non-Pref Brand \$160 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$20
Annual Limit		ICL - \$2,970	All generic drugs covered in the gap (tier 1-2)	All generic drugs covered in the gap (tier 1-2)
Out-of-Plan Svs.	Urgent Care	NA	\$25 in-net / \$50 out-net (anywhere in United States)	\$20 in-net / \$40 out-net (anywhere in United States)
	Emergency Care	NA	\$60 (worldwide) - waived if admitted	\$60 (worldwide) - waived if admitted
Other	Vision VSP	NA	\$20 Exam / 100% Lenses / \$125 Frames	\$20 Exam / 100% Lenses / \$150 Frames
Other	Dental	NA	Preventive Dental Included	Enhanced Dental Included - \$1,500 Max
Other	Fitness Benefit Silver&Fit	NA	Fitness Club Membership Included	Fitness Club Membership Included
Phone Number:			(775) 982-3158	

* You pay 20 percent of the Medicare approved fee plus additional charges if the provider does not accept the Medicare approved fee in full.

** Service Period - There are no additional copayments for Inpatient Hospital-Acute Services when readmitted to a contracted facility during a service period or within 60 days of last discharge.

		Traditional Medicare	SENIOR CARE PLUS Value Rx Premier Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Freedom Rx Premier Plan (PPO) (Hometown Health Plan) Washoe County
		YOU PAY:	YOU PAY:	YOU PAY:
Premium		\$104.90 Part B	\$170 plus \$104.90 Part B Premium= \$274.90	\$205 plus \$104.90 Part B Premium = \$309.90
Hospital Care	1 to 60 days	\$1,184	\$125 per day for 1-3 days (unlimited days)**	\$125 per day for 1-2 days in-net (unlimited days)**
	61 to 90	\$296 a day	\$0	\$0
	91 to 150	\$592 a day	\$0	\$0
	Beyond 150	All costs	\$0	\$0
Doctors Visits Primary Care/Specialist	Per Visit	20% plus*	Preventive \$0 / PCP \$10 / Specialist \$30	Preventive \$0 / PCP \$10 / Specialist \$25 (in-net)
	Deductible	\$147	\$0	\$0
Prescription Copayment Preferred Generic Non-Preferred Generic Preferred Brand Non-Preferred Brand Specialty/Select Diabetic	Pharmacy - 30 days	Full Amount	Tier 1 - Pref Generic \$2, Tier 2 - Non-Pref Generic \$4 Tier 3 - Pref Brand \$40, Tier 4 - Non-Pref Brand \$70 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$10	Tier 1 - Pref Generic \$2, Tier 2 - Non-Pref Generic \$4 Tier 3 - Pref Brand \$40, Tier 4 - Non-Pref Brand \$70 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$10
	Mail Order - 90 days		Tier 1 - Pref Generic \$4, Tier 2 - Non-Pref Generic \$8 Tier 3 - Pref Brand \$80, Tier 4 - Non-Pref Brand \$140 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$20	Tier 1 - Pref Generic \$4, Tier 2 - Non-Pref Generic \$8 Tier 3 - Pref Brand \$80, Tier 4 - Non-Pref Brand \$140 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$20
Annual Limit		ICL - \$2,970	All generic and some brand covered in the gap (tier 1-3,6)	All generic and some brand covered in the gap (tier 1-3,6)
Out-of-Plan Svs.	Urgent Care	NA	\$15 in-net / \$30 out-net (anywhere in United States)	\$10 in-net / \$20 out-net (anywhere in United States)
	Emergency Care	NA	\$60 (worldwide) - waived if admitted	\$60 (worldwide) - waived if admitted
Other	Vision VSP	NA	\$15 Exam / 100% Lenses / \$200 Frames	\$15 Exam / 100% Lenses / \$200 Frames
Other	Dental	NA	Enhanced Dental Included - \$2,250 Max	Enhanced Dental Included - \$2,250 Max
Other	Fitness Benefit Silver&Fit	NA	Fitness Club Membership Included	No Coverage
Phone Number:			(775) 982-3158	

* You pay 20 percent of the Medicare approved fee plus additional charges if the provider does not accept the Medicare approved fee in full.

** Service Period - There are no additional copayments for Inpatient Hospital-Acute Services when readmitted to a contracted facility during a service period or within 60 days of last discharge.

		Traditional Medicare	SENIOR CARE PLUS Freedom Rx Plan (PPO) (Hometown Health Plan) Carson City, Churchill, Douglas, Lyon, and Storey County	SENIOR CARE PLUS Freedom Rx Select Plan (PPO) (Hometown Health Plan) Carson City, Churchill, Douglas, Lyon, and Storey County
Premium		YOU PAY: \$104.90 Part B	YOU PAY: \$64 plus \$104.90 Part B Premium = \$168.90	YOU PAY: \$162 plus \$104.90 Part B Premium = \$266.90
Hospital Care	1 to 60 days	\$1,184	\$275 per day for 1-5 days in-net (unlimited days)**	\$200 per day for 1-5 days in-net (unlimited days)**
	61 to 90	\$296 a day	\$0	\$0
	91 to 150	\$592 a day	\$0	\$0
	Beyond 150	All costs	\$0	\$0
Doctors Visits Primary Care/Specialist	Per Visit	20% plus*	Preventive \$0 / PCP \$10 / Specialist \$40 (in-net)	Preventive \$0 / PCP \$10 / Specialist \$35 (in-net)
	Deductible	\$147	\$0	\$0
Prescription Copayment Preferred Generic Non-Preferred Generic Preferred Brand Non-Preferred Brand Specialty/Select Diabetic	Pharmacy - 30 days	Full Amount	Tier 1 - Pref Generic \$4, Tier 2 - Non-Pref Generic \$10 Tier 3 - Pref Brand \$45, Tier 4 - Non-Pref Brand \$80 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$10	Tier 1 - Pref Generic \$2, Tier 2 - Non-Pref Generic \$6 Tier 3 - Pref Brand \$45, Tier 4 - Non-Pref Brand \$80 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$10
	Mail Order - 90 days		Tier 1 - Pref Generic \$8, Tier 2 - Non-Pref Generic \$20 Tier 3 - Pref Brand \$90, Tier 4 - Non-Pref Brand \$160 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$20	Tier 1 - Pref Generic \$4, Tier 2 - Non-Pref Generic \$12 Tier 3 - Pref Brand \$90, Tier 4 - Non-Pref Brand \$160 Tier 5 - Specialty 33%, Tier 6 - Select Diabetic \$20
Annual Limit		ICL - \$2,970	All generic drugs covered in the gap (tier 1-2)	All generic drugs covered in the gap (tier 1-2)
Out-of-Plan Svs.	Urgent Care	NA	\$15 in-net / \$50 out-net (anywhere in United States)	\$10 in-net / \$40 out-net (anywhere in United States)
	Emergency Care	NA	\$60 (worldwide) - waived if admitted	\$60 (worldwide) - waived if admitted
Other	Vision VSP	NA	\$20 Exam / 100% Lenses / \$100 Frames	\$20 Exam / 100% Lenses / \$150 Frames
Other	Dental	NA	No Coverage	Enhanced Dental Included - \$1,500 Max
Other	Fitness Benefit Silver&Fit	NA	No Coverage	No Coverage
Phone Number:			(775) 982-3158	

* You pay 20 percent of the Medicare approved fee plus additional charges if the provider does not accept the Medicare approved fee in full.

** Service Period - There are no additional copayments for Inpatient Hospital-Acute Services when readmitted to a contracted facility during a service period or within 60 days of last discharge.

2013 MEDICARE PART D BENEFITS COMPARISON CHART
(For use in the 2013 Medicare Supplement and Premium Comparison Guide)

	Traditional Medicare	Humana, Inc. (PDP) Statewide	Humana, Inc. (PDP) Statewide
	YOU PAY:	Humana Walmart-Preferred Rx Plan (PDP)	Humana Enhanced (PDP)
		In 2013 YOU PAY:	In 2013 YOU PAY:
		\$18.50 Montly Premium	\$45.30 Montly Premium
Deductible	N/A	\$325	\$0
		Stage 1	Stage 1
Preferred Retail Pharmacy (30 days)	N/A N/A N/A N/A N/A	Tier 1- Preferred Generic - 100% coinsurance Tier 2- Non-Preferred Generic - 100% coinsurance Tier 3- Preferred Brand - 100% coinsurance Tier 4- Non-Preferred Brand - 100% coinsurance Tier 5- Specialty – 100% coinsurance	Tier 1- Preferred Generic - \$2 copayment Tier 2- Non-Preferred Generic - \$5 copayment Tier 3- Preferred Brand - \$44 copayment Tier 4- Non-Preferred Brand - \$90 copayment Tier 5- Specialty – 33% coinsurance
Preferred Mail Order (90 Days)	N/A N/A N/A N/A N/A	Tier 1- Preferred Generic - 100% coinsurance Tier 2- Non-Preferred Generic - 100% coinsurance Tier 3- Preferred Brand - 100% coinsurance Tier 4- Non-Preferred Brand - 100% coinsurance Tier 5- Specialty – N/A	Tier 1- Preferred Generic - \$0 copayment Tier 2- Non-Preferred Generic - \$0 copayment Tier 3- Preferred Brand - \$122 copayment Tier 4- Non-Preferred Brand - \$260 copayment Tier 5- Specialty – N/A
		Stage 2	Stage 2
Preferred Retail Pharmacy (30 days)	N/A N/A N/A N/A N/A	Tier 1- Preferred Generic - \$1 copayment Tier 2- Non-Preferred Generic - \$4 copayment Tier 3- Preferred Brand - 20% coinsurance Tier 4- Non-Preferred Brand - 32% coinsurance Tier 5- Specialty – 25% coinsurance	Tier 1- Preferred Generic - \$2 copayment Tier 2- Non-Preferred Generic - \$5 copayment Tier 3- Preferred Brand - \$44 copayment Tier 4- Non-Preferred Brand - \$90 copayment Tier 5- Specialty – 33% coinsurance
Preferred Mail Order (90 Days)	N/A N/A N/A N/A N/A	Tier 1- Preferred Generic - \$0 copayment Tier 2- Non-Preferred Generic - \$0 copayment Tier 3- Preferred Brand - 20% coinsurance Tier 4- Non-Preferred Brand - 32% coinsurance Tier 5- Specialty – N/A	Tier 1- Preferred Generic - \$0 copayment Tier 2- Non-Preferred Generic - \$0 copayment Tier 3- Preferred Brand - \$122 copayment Tier 4- Non-Preferred Brand - \$260 copayment Tier 5- Specialty – N/A
		Stage 3*	Stage 3*
Preferred Retail Pharmacy (30 days)	N/A N/A N/A N/A N/A	Tier 1- Preferred Generic - 100% coinsurance Tier 2- Non-Preferred Generic - 100% coinsurance Tier 3- Preferred Brand - 100% coinsurance Tier 4- Non-Preferred Brand - 100% coinsurance Tier 5- Specialty - 100% coinsurance	Tier 1- Preferred Generic - 100% coinsurance Tier 2- Non-Preferred Generic - 100% coinsurance Tier 3- Preferred Brand - 100% coinsurance Tier 4- Non-Preferred Brand - 100% coinsurance Tier 5- Specialty – 100% coinsurance
Preferred Mail Order (90 Days)	N/A N/A N/A N/A N/A	Tier 1- Preferred Generic - 100% coinsurance Tier 2- Non-Preferred Generic - 100% coinsurance Tier 3- Preferred Brand - 100% coinsurance Tier 4- Non-Preferred Brand - 100% coinsurance Tier 5- Specialty – N/A	Tier 1- Preferred Generic - 100% coinsurance Tier 2- Non-Preferred Generic - 100% coinsurance Tier 3- Preferred Brand - 100% coinsurance Tier 4- Non-Preferred Brand - 100% coinsurance Tier 5- Specialty – N/A
Annual Prescription Coverage Limit		Initial Coverage Limit at \$2,970 total drug expenditure	Initial Coverage Limit at \$2,970 total drug expenditure
TrOOP		True Out-of-Pocket Costs \$4,750.00 Member pays the greater of: A \$2.65 copayment for generic drugs (or brand drugs treated as generics) and a \$6.60 copayment for all other drugs; OR 5% coinsurance.	True Out-of-Pocket Costs \$4,750.00 Member pays the greater of: A \$2.65 copayment for generic drugs (or brand drugs treated as generics) and a \$6.60 copayment for all other drugs; OR 5% coinsurance.
Members (800) 706- 0872 or (800) 281 - 6918			

***In the coverage gap:**

From \$2,970 in Rx costs to \$4,750 in Out of Pocket Costs, the member will receive discounts on applicable brand-name drugs and pay only 79% on the cost for covered generic drugs

***In the coverage gap:**

From \$2,970 in Rx costs to \$4,750 in Out of Pocket Costs, the member will receive discounts on applicable brand-name drugs and pay only 79% on the cost for covered generic drugs

		Traditional Medicare:	Clark (partial) and Nye (partial) Counties
		YOU PAY:	Humana Gold Plus HMO H2949 - 009
			In 2013 YOU PAY:
Premium		\$104.90 Part B	\$0 plus Part B Premium
Hospital Care	1 to 60 days	\$1,184	\$25 copay/day - Days 1-5
	61 to 90 days	\$296 a day	\$0
	91 to 150 days	\$592 a day	\$0
	Beyond 150 days	All costs	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	20%	\$0 PCP / \$25 SPC
	Deductible	\$147	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	N/A
	Retail Pharmacy (30 days)	N/A	N/A
	Preferred Mail Order (90 Days)	N/A	N/A
Annual Prescription Coverage Limit		N/A	N/A
Catastrophic Rx Coverage		N/A	N/A
Out of Plan Services	Urgent Care	N/A	\$0 PCP / \$25 SPC
	Emergency Care	N/A	\$50 copay not waived if admitted
Phone Numbers		Members (800) 457- 4708 or (800) 833 - 2364	

		Traditional Medicare:	Clark (partial) and Nye (partial) Counties
			Humana Gold Plus PFFS H2949 – 012
		YOU PAY:	In 2013 YOU PAY:
Premium		\$104.90 Part B	\$0.00 plus Part B Premium
Hospital Care	1 to 60 days	\$1,184	\$25 copay/day - Days 1-5
	61 to 90 days	\$296	\$0
	91 to 150 days	\$592	\$0
	Beyond 150 days	All costs	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	\$20%	\$0 PCP / \$25 SPC
	Deductible	\$147	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	N/A
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$6 Tier 2- Preferred Brand - \$38 Tier 3- Non-preferred brand/generic - \$80 Tier 4- Specialty - 33% Coinsurance
	Preferred Mail Order (90 Days)	N/A	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$104 Tier 3- Non-preferred brand/generic - \$230
Annual Prescription Coverage Limit		N/A	Initial Coverage Limit at \$2,970 total drug expenditure
Catastrophic Rx Coverage		N/A	After \$4,750, member's out-of-pocket copayments would be greater of \$2.65 for generic & preferred multi-source drugs and \$6.60 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	N/A	\$0 PCP / \$25 SPC
	Emergency Care	N/A	\$50 copay not waived if admitted
Phone Numbers		Members (800) 457- 4708 or (800) 833 - 2364	

		Traditional Medicare:	Clark (partial) and Nye (partial) Counties
			Humana Gold Plus HMO-SNP-DB/CHF/CVD H2949 – 013
		YOU PAY:	In 2013 YOU PAY:
Premium		\$104.90 Part B	\$0 plus Part B Premium
Hospital Care	1 to 60 days	\$1,184	\$25 copay/day - Days 1-5
	61 to 90 days	\$296	\$0
	91 to 150 days	\$592	\$0
	Beyond 150 days	All costs	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	20%	\$0 PCP / \$10 SPC
	Deductible	\$147	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	\$0
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$5 Tier 2- Preferred Brand - \$5 Tier 3- Non-preferred brand/generic - \$40 Tier 4- Specialty - \$80 Tier 5- 33% coinsurance
	Preferred Mail Order (90 Days)	N/A	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$0 Tier 3- Non-preferred brand/generic - \$110 Tier 4 - \$230
Annual Prescription Coverage Limit		N/A	Initial Coverage Limit at \$2,970 total drug expenditure
Catastrophic Rx Coverage		N/A	After \$4,750, member's out-of-pocket copayments would be greater of \$2.65 for generic & preferred multi-source drugs and \$6.60 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	N/A	\$0 PCP / \$10 SPC
	Emergency Care	N/A	\$50 copay not waived if admitted
Phone Numbers		Members (800) 457- 4708 or (800) 833 - 2364	

		Traditional Medicare:	Clark (partial) and Nye (partial) Counties
			Humana Gold Plus HMO-SNP-CLD H2949 – 014
		YOU PAY:	In 2013 YOU PAY:
Premium		\$104.90 Part B	\$0.00 plus Part B Premium
Hospital Care	1 to 60 days	\$1,184	\$25 copay/day - Days 1-5
	61 to 90 days	\$296	\$0
	91 to 150 days	\$592	\$0
	Beyond 150 days	All costs	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	20%	\$0 PCP / \$10 SPC
	Deductible	\$147	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	\$0
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$5 Tier 2- Preferred Brand - \$5 Tier 3- Non-preferred brand/generic - \$40 Tier 4- Specialty - \$80 Tier 5- 33% coinsurance
	Preferred Mail Order (90 Days)	N/A	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$0 Tier 3- Non-preferred brand/generic - \$110 Tier 4 - \$230
Annual Prescription Coverage Limit		N/A	Initial Coverage Limit at \$2,970 total drug expenditure
Catastrophic Rx Coverage		N/A	After \$4,750, member's out-of-pocket copayments would be greater of \$2.65 for generic & preferred multi-source drugs and \$6.60 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	N/A	\$0 PCP / \$10 SPC
	Emergency Care	N/A	\$50 copay not waived if admitted
Phone Numbers		Members (800) 457- 4708 or (800) 833 - 2364	

		Traditional Medicare:	Clark County
		YOU PAY:	Humana Prime Choice PPO H9503 – 001
			In 2013 YOU PAY:
Premium		\$104.90 Part B	\$119 plus Part B Premium
Hospital Care	1 to 60 days	\$1,184	\$195.00 copay/day - Days 1-7
	61 to 90 days	\$296	\$100 copay/day - Days 61-90
	91 to 150 days**	\$592	\$0
	Beyond 150 days	All costs	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	20%	\$10 PCP / \$35 SPC
	Deductible	\$147	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	\$0
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$7 Tier 2- Preferred Brand - \$42 Tier 3- Non-preferred brand/generic - \$80 Tier 4- Specialty – 33% coinsurance
	Preferred Mail Order (90 Days)	N/A	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$116 Tier 3- Non-preferred brand/generic - \$230
Annual Prescription Coverage Limit		N/A	Initial Coverage Limit at \$2,970 total drug expenditure
Catastrophic Rx Coverage		N/A	After \$4,750, member's out-of-pocket copayments would be greater of \$2.65 for generic & preferred multi-source drugs and \$6.60 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	N/A	30% PCP / 30% SPC
	Emergency Care	N/A	\$65 copay waived if admitted within 24 hours
Phone Numbers		Members (800) 457- 4708 or (800) 833 - 2364	

		Traditional Medicare:	Washoe County
		YOU PAY:	Humana Prime Choice PPO H9503 – 003
			In 2013 YOU PAY:
Premium		\$104.90 Part B	\$64.00 plus Part B Premium
Hospital Care	1 to 60 days	\$1,184	\$200 copay/day - Days 1-5
	61 to 90 days	\$296	\$100 copay/day - Days 61-90
	91 to 150 days**	\$592	\$0
	Beyond 150 days	All costs	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	20%	\$10 PCP / \$25 SPC
	Deductible	\$147	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	\$0
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$6 Tier 2- Preferred Brand - \$39 Tier 3- Non-preferred brand/generic - \$80 Tier 4- Specialty – 33% coinsurance
	Preferred Mail Order (90 Days)	N/A	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$107 Tier 3- Non-preferred brand/generic - \$230
Annual Prescription Coverage Limit		N/A	Initial Coverage Limit at \$2,970 total drug expenditure
Catastrophic Rx Coverage		N/A	After \$4,750, member's out-of-pocket copayments would be greater of \$2.65 for generic & preferred multi-source drugs and \$6.60 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	N/A	30% PCP / 30% Spec
	Emergency Care	N/A	\$65 copay waived if admitted within 24 hours
Phone Numbers		Members (800) 457- 4708 or (800) 833 - 2364	

		Traditional Medicare:	Washoe County
			Humana Prime Choice PPO H9503 – 006
		YOU PAY:	In 2013 YOU PAY:
Premium		\$104.90 Part B	\$0.00 plus Part B Premium
Hospital Care	1 to 60 days	\$1,184	\$0
	61 to 90 days	\$296	\$296
	91 to 150 days**	\$592	\$592
	Beyond 150 days	All costs	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	20%	20% PCP / 20% SPC
	Deductible	\$147	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	\$0
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$7 Tier 2- Preferred Brand - \$40 Tier 3- Non-preferred brand/generic - \$80 Tier 4- Specialty – 33% coinsurance
	Preferred Mail Order (90 Days)	N/A	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$110 Tier 3- Non-preferred brand/generic - \$230
Annual Prescription Coverage Limit		N/A	Initial Coverage Limit at \$2,970 total drug expenditure
Catastrophic Rx Coverage		N/A	After \$4,750, member's out-of-pocket copayments would be greater of \$2.65 for generic & preferred multi-source drugs and \$6.60 for all other drugs; OR 5% coinsurance.
Out of Plan Services	Urgent Care	N/A	20% coinsurance PCP / 20% coinsurance SPC
	Emergency Care	N/A	\$65 copay waived if admitted within 24 hours
Phone Numbers		Members (800) 457- 4708 or (800) 833 - 2364	

MEDICARE PPOs

A Medicare PPO Plan (A Medicare Part C option) has a list (called a “network”) of primary care doctors, specialists and hospitals that you may go to. You can visit any doctor, specialist or hospital not on the plan’s list, but it usually will cost more. Some Medicare PPO plans offer prescription drug coverage and additional benefits, such as vision and hearing screenings, disease management, and other services not covered under the original Medicare plan. Monthly premiums and how much you pay for services vary depending on the plan. There is an annual limit on your out-of-pocket costs that varies depending on the plan. **Note: It is illegal to be sold a Medicare Supplemental Insurance Policy if you have Part C unless you plan to drop Part C and enroll in traditional Medicare.**

HIGH-DEDUCTIBLE PLANS

The annual deductible for the High-Deductible Plan F is \$2,110¹. Other than the deductible amount, this plan has the same coverage as a regular Plan F. Benefits under this plan will not begin until the out-of-pocket expenses have reached \$2,110. The expenses not paid are the amounts the policy would have paid under regular Plan F, including the Medicare deductibles for Part A and Part B, but not the separate deductible for emergency foreign travel in Plan F. The premium for this plan is significantly less than the regular Plan F. At this time, there are ten insurers offering high-deductible plans (based on the insurers voluntarily participating in this Guide). The following are the names and telephone numbers for these insurers:

¹ The high deductible amount of \$1,500 was initially established in 1999. This amount is adjusted annually by the United States Department of Health and Human Services.

<u>Company</u>	<u>Telephone #</u>	<u>High Deductible Plan</u>
American Republic Corp Insurance Co	1-888-755-3065	Plan F
Colonial Penn Life Insurance Company	1-800-800-2254	Plan F
Humana Insurance Company	1-800-310-8482	Plan F
Liberty National Life Insurance Company	1-800-331-2512	Plan F
Physicians Mutual Insurance Company	1-800-228-9100	Plan F
SecureHorizons by UnitedHealthcare	1-800-768-1479	Plan F
Standard Life and Accident Insurance Co	1-888-350-1488	Plan F
Sterling Investors Life Insurance Co	1-877-896-6434	Plan F
Thrivent Financial for Lutherans	1-800-847-4836	Plan F
United American Insurance Company	1-800-331-2512	Plan F

Plans K and L

Plans K and L provide for different cost-sharing for items and services than Plans A – G and M and N. Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does not include charges from your provider that exceed Medicare-approved amounts, called “excess charges.” You are responsible for paying excess charges.

GUARANTEED ISSUE

Certain people will have a right to **guaranteed issue of a Medicare supplement plan. In order to be eligible for guaranteed issue under any of these six circumstances mentioned below, you must apply within 63 days after losing your other health plan coverage.** The most common conditions for guaranteed issue are as follows:

1. When an employer terminates a group plan or eliminates substantially all supplemental benefits, an individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**
2. When a group plan is primary to Medicare and either the plan terminates or an individual leaves the plan, the individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**
3. An individual who has a Medicare SELECT supplemental policy or is enrolled in a Medicare Advantage plan under Medicare (managed care or private fee-for-service, see pages 34 - 36), and discontinues the coverage because:
 - a. The plan terminates or no longer provides service in the individual's area of residence;
 - b. The individual is no longer eligible for the plan due to a change in residence; or
 - c. The individual can show that the plan:
 - 1) Violated a material provision of the contract; or
 - 2) The agent for the plan materially misrepresented the plan.The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**
4. An individual who is enrolled in a Medicare supplement plan and the coverage ceases because:
 - a. The insurer becomes insolvent;
 - b. Other involuntary terminations occur;
 - c. The insurer violated a material provision of the contract, or;
 - d. The insurer or agent materially misrepresented the plan.The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L.**

5. An individual who terminates a Medicare supplement plan in order to sign up for a Medicare SELECT supplemental policy or a plan under Medicare Advantage, and then terminates the new coverage within 12 months, is **eligible for the same plan** the individual had prior to the change.
6. An individual who becomes eligible for the first time and signs up for Medicare Advantage and terminates this coverage within 12 months is **eligible for any plan.**

MEDICARE SHIP PROGRAM

The State Health Insurance Assistance Program (SHIP) is funded by a grant from the federal government and administered by the Nevada Department of Health and Human Services, Division for Aging Services.

The Program meets one of the most universal and critical needs of seniors and Medicare beneficiaries today: **free** one-on-one assistance and counseling for questions and problems regarding Medicare and supplemental health insurance. SHIP provides the following services:

- Pre-Medicare counseling;
- Information and eligibility on Medicare entitlements, benefits, limitations, Medicaid (Qualified Medicare Beneficiaries & Specified Low Income Medicare Beneficiaries), and Managed Care Plans through Health Maintenance Organizations (HMOs);
- Assistance with claims, requests for reconsideration and appeals processes under Medicare and supplemental insurance;
- Unbiased information that will assist the consumer in determining supplemental insurance and long-term care insurance needs;
- Outreach information and materials for seniors and families through meetings, seminars, classes, health fairs, senior fairs and the media (**speakers available**); and
- Referrals for coordination with federal and other state and community services.

Arrangements may be made for homebound seniors, as well as other seniors, who need personal counseling assistance. Please call **(702) 486-3478** in Las Vegas; and statewide **call toll free 1-800-307-4444**. The services offered by the Program are **free of charge and confidential**. Senior citizens are assured there will be no selling or soliciting for insurance.

MEDICARE COUNSELING PROGRAM

The following is a list of Senior Centers and/or local numbers to contact for counseling with the Nevada State Health Insurance Assistance Program (SHIP):

Southern Nevada

SHIP Office 1820 E. Sahara Avenue, Suite 205 Las Vegas, NV 89104 (702) 486-3478	
Boulder City Senior Center (702) 293-3320	Boys and Girls Club (702) 932-1880
Centennial Hills Hospital (702) 837-9700	East Valley Family Services (702) 631-7098
Heritage Senior Facility (702) 267-2956	Hopelink (702) 566-0576
Las Vegas Senior Center (702) 229-6454	Mountain View H2U (702) 255-5404
Olive Crest (702) 685-3459	Pahrump Senior Center (775) 537-2323
RAGE, Inc. (702) 333-1038	Spring Valley Hospital (702) 853-3276
Summerlin Hospital (702) 804-9706	Sunrise H2U (702) 853-3000
Valley Hospital (702) 894-5512	Whitney Senior Center (702) 455-7576

Northern Nevada

Carson City Senior Center (775) 883-0703	Carson Tahoe Cancer Center (775) 883-0703
Dayton Senior Center (775) 246-6210	Douglas Senior Center (775) 783-6455
Elko County Senior Center (775) 738-5911	Fernley Senior Center (775) 575-3370
Incline Village Recreation Center (775) 832-1310	Inter-Tribal Council of Nevada (775) 355-0600
Neil Road Community Center (775) 334-2262	Pershing County Senior Center (775) 273-2291
Reno Senior Center (775) 328-2575	Silver Springs Senior Center (775) 577- 5014
Storey County Senior Center (775) 847-0957	West Hills Hospital (775) 323-0478

**THE SERVICE OFFERED BY THE MEDICARE SHIP PROGRAM
IS PROVIDED BY TRAINED VOLUNTEERS/ADVISORS
AND IS FREE OF CHARGE**

Please contact the counseling center for times and additional information.

OTHER RESOURCES

Division of Insurance
(702) 486-4009 or (775) 687-0700 or Toll-Free: (888) 872-3234
www.doi.nv.gov

Centers for Medicare & Medicaid Services (CMS)
Toll-Free: (800) Medicare (633-4227)
www.cms.hhs.gov

Social Security Administration (SSA)
(800) 772-1213
www.ssa.gov

National Association of Insurance Commissioners (NAIC)
(816) 842-3600
www.naic.org

Public Employees' Retirement System of Nevada (PERS)
(775) 687-4200 or Toll-Free: (866) 473-7768
www.nvpers.org

Nevada Division for Aging Services
(702) 486-3545 or (775) 687-4210
www.aging.state.nv.us

Governor's Office of Consumer Health Assistance (GOVCHA)
(702) 486-3587 or Toll-Free (888) 333-1597
www.govcha.state.nv.us

Public Employees' Benefits Program
(775) 684-7000 or Toll-Free (800) 326-5496
www.pebp.state.nv.us

As of December 2012

HOW TO FILE AN INQUIRY OR COMPLAINT

If you have an insurance question or problem, you should first contact your agent or company to get the matter resolved.

If you cannot get the matter resolved, contact the **Nevada Division of Insurance** for assistance. Inquiries or questions may be directed to the Consumer Services section at either of the Insurance Division offices.

Las Vegas

2501 East Sahara Avenue #302, Las Vegas
e-mail: edelacy@doi.nv.gov
(702) 486-4009

or

Carson City

1818 E. College Pkwy, Suite 103, Carson City
e-mail: csc@doi.nv.gov
(775) 687-0700

Or, call **toll-free** anywhere in Nevada at

1-888-872-3234

www.doi.nv.gov

The Division of Insurance cannot recommend an insurance company or tell you which policy to buy. Our staff, however, can explain the insurance terminology in your policy to you. The Division of Insurance will also contact the company on your behalf in an attempt to help resolve problems you may be having.

POLICY CHECKLIST

You may find this checklist useful in assessing the benefits provided by a Medicare supplement policy or in comparing policies.

	Policy 1		Policy 2		Policy 3	
	Yes	No	Yes	No	Yes	No
DOES THE POLICY COVER:						
Medicare Part A hospital deductible?						
Medicare Part A hospital daily coinsurance?						
Hospital care beyond Medicare's 150-day limit?						
Skilled nursing facility daily coinsurance?						
Skilled nursing beyond Medicare's limits?						
Medicare Part B annual deductible?						
Medicare Part B coinsurance?						
Physician and supplier charges in excess of Medicare's approved amounts?						
OTHER POLICY CONSIDERATIONS:						
Can the company cancel or refuse to renew the policy?						
What are the policy limits for covered services?						
How much is the annual premium?						
How long before existing health problems are covered?						

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